CONTINUING DISABILITY CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.
This form is for the continuation of a previously approved disability claim. To establish a claim for a new disability you must use form S00198 for a disability due to an accident or form S2029 for disability due to sickness.

FOR ASSOCIATE USE ONLY:

☐ **Send the insured's check to the associate for delivery.** **Writing No.:** _____ **Name:**_____	**Address:** _____ _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

FILING CLAIM FOR:

Disability Policy Number: ☐ Accidental Injury ☐ Sickness ☐ Pregnancy ☐ Complications of Pregnancy

SECTION A: PATIENT/POLICYHOLDER INFORMATION: Please print.

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
LAST FIRST INITIAL			LAST FIRST INITIAL		
☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER	BIRTHDATE		ADDRESS CHECK IF NEW ADDRESS ☐		
RELATIONSHIP TO POLICYHOLDER: ☐ SELF ☐ SPOUSE			CITY	STATE	ZIP
SOCIAL SECURITY NUMBER (optional)	PHONE NUMBER		SOCIAL SECURITY NUMBER (optional)		BIRTHDATE

SECTION B: PHYSICIAN'S STATEMENT: Please print. Must be completed by physician or physician's staff.

PHYSICIAN'S NAME	ADDRESS	PHONE NUMBER

1. Has the patient been treated for this condition within the last 6 months? ☐ Yes ☐ No Date of last treatment: _____/_____/_____
2. First date of disability: _____/_____/_____ Ending date of disability: _____/_____/_____
3. Diagnosis description and ICD code: _____
4. If pregnant, date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean If not delivered, expected delivery date: _____/_____/_____
5. Date released from your care: _____/_____/_____ If not released, next appointment date: _____/_____/_____
6. Was patient hospitalized? ☐ Yes ☐ No If yes: Admission: _____/_____/_____ Discharge: _____/_____/_____

Hospital Name: _____ City: _____ State: _____

PHYSICIAN'S SIGNATURE _____ DATE _____ TAX ID NUMBER _____

SECTION C: EMPLOYER'S STATEMENT: Please print. To be completed by Employer if filing for disability.

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

1. Is this person still employed? ☐ Yes ☐ No If no, date left employment: _____/_____/_____
2. Is employee currently working? ☐ Yes ☐ No If yes, is employee working: ☐ full-time? ☐ part-time? ☐ light duty?
3. If part-time or light duty what is the release date to return to work full-time? _____/_____/_____
4. Is the employee currently earning at least 80% of their salary prior to disability? ☐ Yes ☐ No

EMPLOYER'S SIGNATURE _____ TITLE _____ DATE _____

American Family Life Assurance Company of Columbus (AFLAC)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)